STATE OF CALIFORNIA
Department of Industrial Relations
Division of Workers' Compensation

PUBLIC HEARING
Monday, January 14, 2008
The Ronald Reagan State Office Building
300 South Spring Street
Los Angeles, California

Carrie Nevans
Active Administrative Director

Destie Overpeck
Chief Counsel

Suzanne Marria
Industrial Relations Counsel

Maureen Gray
Regulations Coordinator

Reported by: Linda Temple
Barbara Brown

I N D E X

PUBLIC HEARING

LOS ANGELES, CALIFORNIA

MONDAY, JANUARY 14, 2008; 10:06 A.M.

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MS. OVERPECK: Thank you all for coming. We're going to be discussing the regulations for the QME Regulations. They are sections 1 through 159 in Title 8.

My name is Destie Overpeck. I'm the Chief Counsel at the Division of Workers' Compensation. This is Carrie Nevans our Administrative Director, and Suzanne Marria who basically wrote the regulations today. Maureen Gray, who is sitting right over here, is our Regulations Coordinator.

If you have any written comments that you brought with you that you want to turn in today, please give them to her. You have until, I think, 5:00 on the 17th to turn in written comments. You can e-mail them to us. You can fax them to us, or you can just make sure they get there in hard copy.

Because there's so few, I doubt that we will need to take any breaks. We will probably be done somewhat quickly today. We have a sign-in list, and we will call through the names of those who have checked that they want to testify. When you do, please, if you have a business card, bring it up to one of the court reporters. And then

state your name and spell your name and then proceed with your comments. And if any of you decide you want to comment, you haven't checked, we will call at the end to make sure that everyone has had an opportunity.

We will be carefully considering all comments. If we, after receiving all the comments statewide determine that we need to revise our regulations, we will send them out for another 15-day period. And during that period, additional comments can be made. And, again, if you signed up on our sign-in sheet, you will be sure to receive a copy of the next revision. All right. I think that's all I need to say initially.

So let's start with Linda Atcherley, please.

LINDA ATCHERLEY

MS. ATCHERLEY: My name is Linda Atcherley, A-t-c-h-e-r-l-e-y. I'm a Legislative Chair for the California Applicants' Attorney Association.

First of all, we do have written comments, but they will be prepared and submitted at the October -- January 17th hearing. So I'm not going to go through each section we have a problem. But I'd like to hit some of the main points. And this isn't particularly a main one, but on section 11 sub 3 paragraph 1 -- everywhere else in the code the QME has to have an unrestricted California license. And

in these regs it just says "unrestricted license," and it probably should be amended to say "unrestricted California license."

One of the major areas where we have a concern is section 31.1(b). And this, along with some other sections, deals with getting additional panels. So a person -- obviously for the simplest of injuries it doesn't really matter, somebody just breaks an arm or has an amputation injury. But one of -- and I don't mean to diminish amputation injuries. But they seem to be -- they're fairly localized.

But somebody that falls through a roof and has head injuries, neck and back injuries, knee injuries, multiple body parts -- a lot of times it's very difficult to get a screen physician to handle all the body parts to begin with. And certainly you end up with issues where you have psychiatric injuries, you have internal injuries, you have all these different areas that have to be addressed.

And we've got a two-year TD cap running. And so the time lines -- if you have to keep going back and forth to the medical director to issue additional panels and have to explain why you need an additional panel and what you went through to try to get the additional panel with an AME for each of these body parts -- and this also goes to comments also valid for the compensable consequence problems

where someone comes in with an orthopedic injury and ends up having some internal issues, hypertension, psychiatric injuries, depression as a result of the orthopedic injuries. And so, you know, we do a lot on the practitioner end to try to get AMEs in these different -- in these different areas.

And to explain, you can write a letter really quickly. I think you need a psychiatric evaluation if you agree to an AME that's done right there. And I don't think the process should be anymore burdensome when you're going through the panel QME process than the AME process. So if you need an additional panel of a QME, then I think you should be able to get it without significant delay and more documentation.

And also, you know, we're kind of stuck with the AMA Guides for better or for worse. And the AMA Guides do divide up an entire body into body systems. And so when you have Labor Code section 4660 -- which I think these regulations need to be consistent with as well -- Labor Code section 4660 requires that the physician describe the impairment in terms of the AMA Guide's Guidelines To Grading Permanent Disability, 5th Edition.

And so if you have to describe the person's disability using the impairment language, you have to by necessity discuss whether they in a scar -- in a surgical scar issue -- not just whether there is neurological damage

under the neurological chapter. But you also have to describe what's happening with the skin, what's happening with the internal components, if they're taking a lot of medication. And this arises under a pain management guide.

The problem is the doctors just simply do not -- the doctors themselves do not take on every single component of the body part when they're doing either treatment or a QME evaluation. And so we'd like to have a little bit more liberality in the issuances of additional panel QMEs, especially if we want to start relying on that methodology more than the AMEs, which take a long time to actually get.

And along those lines under section 31.1 -- and I also realize that multiple panels and an ease of getting multiple panels can lead to some abuse. But I think we have to balance some of the equities of people that have all these different problems that the doctors themselves -- the underlying
problem -- that they do not address those problems or even recognize it sometimes because of their own subspecialties -- that an orthopedist doesn't necessarily look at the internal, evaluate the internal. They think someone looks depressed, but they're not going to evaluate the psychiatric aspects.

Some of these guys do spines only, and they're going to ignore a knee or an elbow. And that's really a

problem when you're trying to really flush out under the AMA Guides what the proper impairments are, and what the overall disability is.

So also under 31.1(b) paragraph 2, form 111, this paragraph provides us good cause to request an additional QME panel where the AME or QME advises the parties and the medical director that another specialty is needed.

And so what we simply advise is just adding a couple more questions to make that absolutely clear on the Findings/Summary form, that they are making a request. Otherwise, we will never know if they asked a medical director or anybody else what made those requests.

So under section 30(c), it allows the medical director to delay issuing a QME panel until the parties answer requests regarding the previously issued panel.

Again, the concern here is for delay when we've got a two year TD cap running, and these panels -- QMEs aren't always being asked to address simply issues of permanent disability, but a lot of times is whether a modality of treatment is necessary.

So the speediness of getting that panel QME out is probably paramount to make sure the person has a financial wherewithal to undergo the treatment should it be authorized.

The other big problem we're having -- and I know

that you are really trying hard to address this -- is under section 30(f). And this is with people that have multiple practice locations throughout the State of California.

And you put a weight factor of 1.5. This is an example of what happens here -- how a member of San Hose's examiners' list of QMEs for a particular specialty -- there are 47 individuals on the list. Twenty-seven of those individuals were physicians who had their primary offices outside of the San Jose area. So we still want to have local physicians to have some statistical relevance.

And if you -- in a situation like the one I just described -- even with the weighting of 1.5 of the primary practice locations, you still are going to get some statistical irrelevance of the practicing physician. And the vast majority consists of mainly out-of-area physicians.

So the only -- and I mean this is a really difficult question or problem to even address. But we do notice that there is a definition of primary practice location. And so I think only the primary practice location should be included in the QME list where the doctor actually does some practice where it's a real office, not a store front -- which some of these are -- or a hotel room, which have occasionally been used or somebody else's doctor's office that they're borrowing for the day, you know. And I -- I understand it, you know. Doctors are leaving the

practice.

So you've got to weigh some of these things against, you know, not having these doctors at all. But, you know, we ought to give the guys in the area a fair shot.

All right. So section 31.1(b): This is a case where the represented party requests a panel specialty other than the treating physician and then submitting relevant documentation supporting the reason for a different specialty.

The problem is that if you look at how some of the -- the problem is in the designation of relying on the treating physician's specialty as the reason why you should get a panel in that specialty, you know. I think that there should be some balance.

Clearly somebody that has a neuropsychological problem and is asking for a podiatrist, may not be appropriate. But, you know, when you are in this area -- realm of orthopedists and neurologists and internal and pain management, you have oftentimes people going to a clinic sent by the doctor and then they don't even see the same doctor. They see doctor so and so the first time and a physician's assistant and some other doctor. And if you look through the reports, they're being signed and certified with different doctors.

So if you don't have -- and then the problem that I

had described before -- in a far more complicated case you have your orthopedist doing the spine. You have your orthopedist doing the hand. You have -- then you have a psychiatrist. And ultimately the real person to look at is a physiatrist. Or even a panel in chronic pain, which I've noticed you collapsed to include anesthesiologists, which may not be appropriate.

So if somebody is treating with an orthopedist and you request a pain management panel, I don't think that you need to have a large amount of documentation to do that. All this does is provide a lot of delay.

And in the days when the carriers paid for the delay, I suppose I wouldn't have been quite so -- so concerned about it. But in this area where the injured worker is paying for the delay, I think we have to be very concerned that we don't put things into a situation where the person -- who cares what the doctor says if the person is out on the street. I'm not just being overblown on these things.

I get so many requests of people that can't pay their mortgage. They can't pay their car payment. They can't pay their food on the table, you know -- the kids. And, you know, you just do the best you can sometimes. You lend them money if you have it. And so any delay here is really -- really provides a tremendous burden on the injured

worker, represented or unrepresented.

What we're trying to do is get through the system as quickly as possible, and get disputes resolved as quickly as possible. And that's both for the employer end and the employee end. No one wants to pay benefits that aren't due, and everybody wants people back to work.

So where we can streamline the process and not have to submit a whole bunch of documentation -- unless, you know, in cases particularly egregious, like the one I just mentioned, where you've got a head injury and treated with a neuropsychologist and you have a podiatrist panel -- I would have a problem with that. And I would assume the medical director logically would as well. Or maybe not.

31.1(c): This states that when the medical director fails to issue a panel to a represented employee within 30 days, either party may seek an order from a workers' compensation judge.

But under Labor Code section 139.2(h)(1), if a panel is not assigned within 15 working days, an unrepresented worker shall have a right to a QMA of his or her choice. And so the differential in these two time lines seems to unfairly impact an injured worker that sought representation, for many reasons. Some of them language based. But they shouldn't have a larger timeframe under -- they shouldn't be put at a disadvantage on timeframe simply

because they are represented.

MR. ZEIDNER: Ms. Atcherly, what section are you referring to?

MS. ATCHERLEY: Section 31.1 subdivision C.

But anyway, you shouldn't be at a disadvantage from simply having been represented.

And the other subsection 35.5 subdivision (b) -- and this -- I'm not going to go into it too much here. But we all want the doctors to address treatment guidelines and adhere to the treatment guidelines. And it actually refers to -- but I'm not sure that this regulation really is the way to go about making sure that they do that. But -- and I think maybe we can work on that a little bit longer to make sure that we have a better handle on that.

But as I said, Sue Borg will be testifying in Oakland, and we will have a finalized draft of a letter on all the different QME regulations on October 17th.

So I appreciate your time you've given me. If you have any questions, I'll answer them. Otherwise, I'll step aside.

MS. OVERPECK: Thank you, Linda.

The next name that we have is Steven Becker.

MR. BECKER: Thank you. I gave a copy to Ms. Gray. I kind of want to read this, but I kind of want to be casual and speak from my own mind.

Basically I -- I'm here just to talk about the proposed sections -- I think it's 12 and 13 -- for chiropractic subspecialties.

And in reviewing your proposed changes, this was supposed to be due to changes from SB 228 and SB 899 to kind of, what I assume, is incorporate them into the Labor Code. I think I read also somewhere in the proposal that the proposed changes -- I'm not sure if it was just for the chiropractic subspecialties -- was to clear up some public confusion.

But in reading your -- I guess your Citations and Authorities -- I basically read, you know, Labor Code section 53, 111(a), 133, 139.2, 5307.3. And in reading those sections, it read that, I guess, the administrative director can do all things necessary to in the exercise of your powers -- that
you -- can allow you to adopt or amend any rules that are reasonably necessary to enforce.

I didn't read in there -- obviously I'm not a lawyer -- where you have the ability, respectfully, as respectfully as I can -- where you have the authority to

rewrite the laws of California.

This Labor Code is not -- nothing in the proposed changes, in my opinion, is exercising or enforcing in these sections. Sections 12 and 13 are exercising or enforcing the completely gutting, if not rewriting, chiropractors' specialties out of the books. And I assume the legislature -- if the legislature had chosen to do that, the legislature would do that.

I -- over the period that the proposed changes were made, I made numerous phone calls. I made numerous phone calls to Ms. Marria, to Ms. Nevan's assistant. I spoke to the Board of Medical Examiners, trying to ascertain where in the code you see that.

For example, the Medical Board recognizes specialties. It's clearly not in the Chiropractic Act. I will grant you that. Part of that may be that the Business and Professions Codes allows chiropractors to advertize their specialties.

After all the calls, I finally got through to the Medical Board, and the Information Assistance Officer. And they informed me that the same Business and Professions Code, not the Medical Practices Act, not the Medical Board itself, but the Business and Professions Code from California allows the recognition of certain specialties under the American Board of Medical Specialties and a few

others. It also allows the Medical Board, I think, to recognize certain boards. I think maybe they've recognized four to date. I could be mistaken.

But they do not -- basically the response I got back from the Medical Board was they have no codified policy on recognizing any boards. It's in the Business and Professions Code.

Now, the Business and Professions Code -- I think it's section 651 -- allows for chiropractors to advertize. It prohibits physicians, I think, a little bit more. It's more detailed. There are prohibitions for advertizing, but it allows for chiropractors. To say that the California Chiropractic Board doesn't allow or doesn't recognize those specialties -- perhaps that is -- because the Business and Professions Code allows it.

So to say, "Well, gee. The California Chiropractic Board doesn't allow it," is not the same as -- they certainly don't disallow it. So to say that, "Well, gee. They're not allowed or they're not recognized," is completely different. It's only like one half -- it's like a half truth.

They are permitted. They're not prohibited. And basically I think it's the legislature's job -- the Business and Professions Code allows for it -- the legislature -- there's no current -- recent lawsuit, legal need for a

change in chiropractic specialties that requires this change. I don't see where this was studied, you know.

Again, I think I read -- and forgive me if I'm mistaken -- the public confusion about chiropractic specialties. There is no chiropractic -- there is no confusion that I'm aware of. There's certainly no confusion that the Chiropractic Association was aware of. There's certainly been no confusion for the last 15 years that I've been a chiropractic QME and with specialties. There was no problem or confusion when the IMC was in charge of that. And certainly if there is some confusion, it hasn't been described. It hasn't been pronounced. It hasn't been studied, how these changes are going to correct any deficiencies.

And so it seems a little, you know -- not disingenuous. But it just seems unsupported, where these are coming from. You know, to basically lump all chiropractors together is, you know -- there is no problem that requires this fix. So that's -- I guess that's the summary of my -- my comments.

But again, respectfully, I know you have a difficult task to do. But I think that the chiropractic subspecialties don't require this type of fix, or I would assume the legislature would have requested that in some way or pronounced that, that there would be some legal need for

this change to occur. And I'm not aware of it. Thank you.

MS. OVERPECK: Thank you very much for your testimony.

Our next -- okay. That's all we have listed up here.

Is there anyone else in the audience who would like to come up and testify?

Mr. Webb?

Linda Temple

Official Hearing Reporter

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MS. OVERPECK: Okay. That's all we have listed up here. Is there anyone else in the audience who would like to come up and testify?

Mr. Webb.

MARK WEBB

MR. WEBB: Thank you. My name is Mark Webb. I'm the vice president for state relations with Employers Direct Insurance Company.

We will be providing written comments, but I just wanted to focus on one particular section of the proposed regulations, Section 11.5, subdivision (i), paragraph 3 dealing with the language of the reports. The task you're engaged in is very positive, and bringing these regulations up to standard with AB 227, SB 228 and SB 899 is not only very important for right now but also to have some recognition that permanent disability is still somewhat of a fluid concept given the cases that are currently pending in front of the Appeals Board.

So with that in mind, one of the curriculum items here is factors of disability including subjective and objective factors for cases involving dates of injury not subject to the AMA Guide-based impairment rating system. I would recommend that you replace that with a date certain or at least as best as you could. Primarily because, as we

know, the Sixth Edition of the AMA Guides is soon to be out there, and there well may be situations where the Administrative Director decides to incorporate different or new definitions of disability that are not framed within the AMA Guides, Fifth Edition. And I would hate for this curriculum -- and recognizing this is only curriculum, this is not a change in the substantive law -- but I would hate for this curriculum to suggest to a QME or an AME that objective-subjective has vitality post the 1-1-05 permanent disability rating schedule which is why I would recommend that this would be a date certain within the language of 4660, understanding how it applies to pre-1-1-05 injuries in certain limited circumstances because I think that's what you're trying to accomplish here. But, again, given that there may be situations where you have definitions of disability that are not part of the AMA Guides, Fifth Edition, I don't think you want to be in the position where there is still vitality of objective-subjective considerations post 1-1-05.

Given the somewhat fluid nature of what the Appeals Board is looking at in terms of defining permanent disability or, more important, how it is defining how you can rebut the prima facie level of disability established by the rating schedule, I think there is a question of the role of training of occupational history, work restrictions, loss

of pre-injury capacity and vocational rehabilitation post AB 227 which repealed the mandatory vocational rehabilitation benefit and post the new permanent disability rating schedule adopted 1-1-05 and any adjustments that you want to make to that in your current -- well, what hopefully will be a soon current rulemaking process as well.

Given the -- I think the pending issue of the vitality of the Le Boeuf case in rebutting the permanent disability rating schedule, there is at least a question of whether you're train QMEs to make the exception to the schedule or significant to the schedule itself. But I think that as we move forward it may not -- from a timing standpoint it may not work for this rulemaking proceeding. But I think as we move forward, these criteria need to be put in the context of what we might anticipate the courts doing in terms of what's necessary to rebut the schedule. I also think that, again, how do these criteria fit in the current schedule and factors to be taken into consideration for dates of injury to which the new schedule applies, and I think that clarification should be in there as well.

We'll put this and some other comments into writing but that's all I wanted to bring to your attention today. Thank you.

MS. OVERPECK: Thank you.

Is there anybody else in the audience who'd like to

speak? Please come forward.

ROBERT B. ZEIDNER, ESQ.

MR. ZEIDNER: Thank you for allowing me the opportunity to address the Administrative Director and panel. I'm here -- my name is Robert Zeidner and I'm here on behalf of the California Applicants' Attorneys Association and I'm one of the co-chairs of the regulations committee. And we spent quite a bit of time going through these proposed regulations and we definitely appreciate the time and thought that the Administrative Director and her staff have put into -- into putting these proposed regulations together, and for most -- for the most part I think that they will help the system.

I think it's the consensus that we do need emphasis in certain areas and maybe de-emphasis in certain other areas. I just wanted to bring up a couple of points that I think really address the concerns of the entire system, not just the Applicants' attorneys side or the applicants' side. One of the things -- and I came in and I apologize. I came in the middle of Linda -- Linda Atcherley's discussion. So if I hammer on a point that she's already brought up it just means that it's really to be emphasized.

And so I want to address Section 30, subdivision (d) that the determination of the judge after the 90-day consideration period, or what we call "denial period," the

investigatory period after a claim is filed, we strongly object to any language which would give a judge the power to order further QME evaluation which would extend that 90-day period. That 90-day period is kind of a sacred cow I think to everyone. It gives the insurance and the employer and the administrator -- claims administrator a boundary within which to investigate the claim, to gather evidence which will support or deny -- support or reject the claim. But most importantly, it prevents an undue and an unfounded extension of time the way its written whereby a judge can order further physicians' opinions to decide whether a claim is compensable or not. That's all supposed to be done in a 90-day period. And I think what the -- what the rule says here is that basically a judge has the power, and although they may do it -- and they may have the power statutorily and by case law, we object to any language in here which would add emphasis onto that power to extend the investigative period beyond the 90 days.

The other thing that needs to be emphasized, and I -- actually I think I came in the middle of Ms. Atcherley's discussion of it, is that every time an Applicant or an Applicant's attorney needs to go to court to get an additional panel QME, it's another two- or three-month delay. Even on an expedited calendar where there is -- the claim is admitted but maybe there is a body part in dispute.

It really presents a hardship to the Applicant to have to wait. If you could only imagine the process. We have to file a DR, we have to serve notice on the other side, we have to go down to court, maybe there is a continuance. And just to get an order to get an additional panel is really a burden. So we're hoping that the Administrative Director might revisit these specific sections. For example, 31.1, subdivision (c) where there is language -- that you got to go to court to do all this.

If the Administrative Director wants us to get a court order to do this type of thing, perhaps there may be some kind of written procedure rather than necessitating the appearance in court. Perhaps the filing of a petition with notice to the other side: In the absence of -- in the absence of a showing of good cause, further panel QME is required. And maybe that will -- that will bypass the time that we will take in order to go down. And I'm not sure that we don't have the power to do that, but right now we'd like something in writing that might emphasize that ability.

Also procedurally, when information is directed to a QME or an AME, one of the important things that we want in these regulations is that there be some structure with regard to the information that is transmitted to the QME or AME in writing. And what we're really talking about is getting -- it's almost always the employer's or their claims

administrator's job to copy all the records and transmit those records to the doctor. And I think the best mechanism for doing this is to require an inventory of all medical documentation and any other information -- evidentiary information that they feel that the doctor ought to have. And the reason why we want an inventory prepared -- and we would have the same burden if it for some reason fell upon us to copy the medical record and all the evidence -- is that when you get a stack of records a foot high and the letter to the doctor merely says, Enclosed you will find all previous medical reports and evidence which we feel it necessary for you to review, then our staff has to sit down and go through that -- that pile and make sure and compare it with our evidence and make sure that everything that's in there conforms with what we have. We can't rely on the employer's or the carrier's representation that they've transmitted all the records. Mistakes happen, things are left out. They may not have things that we have. So we'd like there to be something in there that requires them to inventory it, and it will make matters much easier for both parties.

I think the last comment I have -- and, of course, as Ms. Atcherley said, we have proposed a lengthy letter addressing our concerns with many of these sections. But I think these are the high points. When we're talking about

Section 35.5, subdivision (d), and this subdivision requires that an evaluator's opinion must be consistent with the standards of evidence-based medicine as set out in 9792.2, and while we recognize that the legislature intended that reasonable medical treatment be based on evidence-based peer review nationally-based standards, we believe that the requirement for them to cite studies to elaborate on this is unduly burdensome.

I think the doctors, the QMEs in the past have done a good job, the AMEs have done a good job. We're there to ask questions if we have concerns about whether or not their reports are evidence-based. But we have a very strong concern that if doctors have to go to the textbooks and to the medical libraries to bolster their opinions regarding treatment, we're going to drive more of our valued doctors out of the system both, you know, whether they're reporting for the applicant and if their reporting for the employer or the claims administrator or they're strictly AMEs and/or QMEs and they've been obtained to a panel. We don't want them unduly burdened with research and elaborate -- beyond reasonableness elaborate supplementation with evidence-based studies. So we feel that maybe the statute -- I mean the regulation, 35.5, subdivision (d), may be couched in a little bit less mandatory or definitive terms so that the doctors don't feel that they're unduly burdened with the

task of citing all these studies that they're basing their opinions on. And that's really it.

So I think the gist of our -- of our major concerns, one, is, as Linda Atcherley, said we don't want unrepresented injured workers to have greater rights than represented injured workers. There is some portions, as Ms. Atcherley pointed out, in these regulations where time lengths are longer for unrepresented injured workers than they are for represented injured workers and that obviously penalizes an injured worker for obtaining legal counsel. And if truth be told, it often takes longer for the represented injured worker and his counsel to get the information they need to integrate it with the file. So we'd like at least to be on equal footing with the unrepresented applicants.

We'd like less burdensome procedures for getting additional panel QME. I think Ms. Nevans heard a little bit about that when she graciously came to speak at CAAA's strategic planning last November, and I think Ms. Nevans was very supportive of streamlining that procedure to get additional panels. And I think that says it all so far.

MS. OVERPECK: All right. Thank you for your comments.

MR. ZEIDNER: Thank you.

MS. OVERPECK: Is there anyone else in the audience who has a comment today?

(No response.)

MS. OVERPECK: All right. Thank you. We will then close this public hearing, and I'd just like to remind you that we will be accepting written comments until January 17th. Thank you.

Barbara Brown
Official Hearing Reporter

(The hearing concluded at 10:51 a.m.)

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C E R T I F I C A T I O N

I, Gail Paige-Washington, Official Hearing Reporter for the State of California, Department of Industrial Relations, Division of Workers' Compensation, do hereby certify that:

The foregoing matter was reported by Linda Temple and Barbara Brown, Official Hearing Reporters for the Division of Workers' Compensation;

The preceding transcription of proceedings was accomplished via computer-aided transcription, with the aid of audiotape backup, to the best of our ability.

I thereafter merged the respective sections of the electronic file portions of transcript to produce this transcript of one volume, being transcription of the proceedings held on January 14, 2008, to the best of our ability.

Dated: January 18, 2008

Gail Paige-Washington
Official Hearing Reporter
Division of Workers' Compensation